STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325032	A. Building B. Wing	04/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sandia Ridge Center	2216 Lester Drive NE Albuquerque, NM 87112

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35632 Based on record review and interview the facility failed to prevent resident to resident abuse for [R #1] of 3 [R #1, R #2 and R #9] residents reviewed for sexual abuse by R #2 sexually assaulting R #1. This deficient practice likely resulted in psychosocial harm to residents. The findings are. A. Record review of the facesheet for R #1 indicated the following, R #1 was admitted on [DATE] for the following Diabetes Mellitus Type 2 (your body doesn't use insulin properly) right carotid artery occlusion (occurs when fatty deposits (plaques) clog the blood vessels that deliver blood to your brain and head), major depressive disorder (clinical depression, is a mental disorder characterized by at least two weeks of pervasive low mood, low self-esteem, and loss of interest or pleasure in normally enjoyable activities), insomnia (sleep disorder that makes it hard to fall asleep), Irritable bowel syndrome (IBS) (is a common disorder that affects the stomach and intestines, also called the gastrointestinal tract) and hypertension (high blood pressure). Unspecified dementia with behavioral disturbance (symptoms affecting memory, thinking and social abilities severely enough to interfere with your daily life). This is not an all inclusive list. B. Record review of the Minimum Data Set (MDS) dated [DATE] indicated that R #1 had a BIMS (Brief Interview for Mental Status) score of 4 (0-7 severely Impaired cognition, 8-12 moderately impaired, 13 -15 intact cognition) and resided on the locked unit for wandering behavior. C. Record review of the care plan revised on 12/06/22 indicated the following: R #1 has a tendency to exhibit sexually inappropriate behavior R/T (related to): Cognitive Loss/Dementia. (name of R #1) has consent from R #1's POA (Power of Attorney) to have an intimate relationship with R #2. R #2's POA provided consent. D. Record review of the facesheet for R #2, indicated that R #2 was admitted on [DATE] and had the following diagnosis of extradural and subdural abscess (infections in the brain), dementia (symptoms affecting memory, thinking and social abilities severely enough to interfere with your daily life), dysphagia (difficulty in swallowing food or liquid may interfere in a person's ability to eat and drink), chronic hepatitis C (viral infection that causes liver inflammation, sometimes leading to serious liver damage) and Wernike's encephalopathy (or wet brain is the presence of neurological symptoms caused by biochemical lesions of the central nervous system). This is not all inclusive list. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Actual harm Residents Affected - Few	E. Record review of the Minimum Data Set (MDS) dated [DATE] indicated that R #2 had a BIMS score of 5 (0-7 severely Impaired cognition, 8-12 moderately impaired, 13 -15 intact cognition) and resided on the locked unit for elopement (leaving) and wandering behavior. F. Record review of the care plan for R # 2 revised on 12/06/22 indicated the following: R #2 has a tendency to exhibit sexually inappropriate behavior R/T: Cognitive Loss/Dementia (name of R #2) has consent from R #2's POA to have an intimate relationship with R #1. R #1's POA provided consent. G. On 04/05/23 at 10:00 am during an interview with Licensed Practical Nurse (LPN) #1, she stated that R #2 could be touchy feely and at times aggressive. He was on the locked unit because would sought to exit all the time. LPN #1 stated that just last week he got out the backdoor of this unit and kicked the wooden gate and started running down the street. She stated that he had a plan and had a bag with him. She stated that as of last week his behaviors had been escalating. She stated that R #2 hit another resident after the elopement incident, and then the sexual assault incident with R #1. LPN #1 stated that she witnessed this incident. LPN #1 said that on Monday 04/03/23, that she heard R #1 scream stop you're hurting me. LPN #1 was around the corner at the mediation cart when she heard R #1 say this. When she walked around into the dayroom she saw R #2 with his hands under R #1's dress. LPN #1 stated that R #2 was being forceful and aggressive with R #1 and wouldn't stop. They tried to pull his arm away from R #1 but they couldn't. Finally he (R #2) got mad and stopped, and started threatening and calling them fucking bitches. LPN #1 stated that she took her (R #1) to her room to make sure she was physically alright and changed her dress to a pair of sweatpants. At that point LPN #1 stated that she notified everyone and the investigation started. She stated that after this incident she saw in the care plan where it indicated in both R #1's and R #2's Power of Attorneys had stated that these two residents were allowed to be in an intimate relationship. LPN #1 stated that when she spoke to POA (daughter) of R #1, she was very upset about this, indicating that she had no idea that the care plan stated she had given permission for them to have an intimate relationship. H. Record review of the nursing progress notes indicated the following: On 4/3/2023 20:09 (8:09 pm. Today, the Administrator met with the (name of) Police Department, SANE (Sexual Assault Nurse Examiners), and (name of) Detective regarding the sexual abuse incident that took place earlier in the day. (name of detective), along with SANE, strongly advised against (name of resident #2) returning to the facility due to the potential danger he poses to both the abused resident (R #1) and other residents. As such, they recommended a restraining order be put in place for the facility and family. The son of the abused resident (R #1) worked closely with Detectives and SANE to complete the restraining order, which was received at approximately 5 pm. SANE also conducted an evaluation of the abused resident (R #1), and results are currently pending. The facility promptly notified Adult Protective Services (report number 301988) and the state Ombudsman of the incident. I. Record review of the progress note dated 12/05/22 indicated the following: At the beginning of the night shift around 6:35, the nurse was summoned by the CNA (Certified Nurse Assistant) to go and witness the resident (R #2) and (name of R #1) in his room. Upon assessment the resident was lying in his bed naked half covered by his blanket and (name of R #1) was sitting leaning on the residents' waist her legs suspended on her wheel chair. (name of R #1) had her black slack, printed shirt and her brief on. When the nurse asked the resident why (name of R #1) was in his room, he replied she is my girl friend and we are watching TV. The residents were accompanied to the dining for close monitoring . (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	J. Record review of the progress notes dated 09/05/22 indicated the following: resident continuously trying to take a female resident into a vacant room. When told he cant be alone with her in the room resident is becoming aggressive with staff calling CNA's and nurses bitches, throwing finger. Stating you guys are a bunch of snitches your always telling on me. K. Record review of the progress notes dated 06/09/22 for R #2 indicated that he is experiencing impulsive behavior and often holds hands of female Pt's (patient) and sits with female Pt's exhibits behavior: seeking companionship (e.g. looking for a loved one). Additional mental health/behavior comments: Pt will hold female Pt's hands while sitting in dining room. Will sometimes kiss a female Pt and has to be told to stop. Pt is currently resting in bed. Pt is a 1:1 watch for sexual behaviors exhibited on day shift. No behaviors noted so far this shift. L. On 04/05/23 at 1:15 pm, during an interview with the Ombudsman she stated that she had not been made aware that the facility was allowing these two residents to be intimate with each other. M. On 04/05/23 at 1:30 pm, during an interview with R #1, she stated that she had a friend, that was her friend, but weren't those kind of friends and he hadn't touched her. She also had a friend like that and he touched her in a way she didn't like at least one time. R #1 was unable to give any other details of the names, places, or events. N. On 04/05/23 at 2:26 pm, during an interview with R #1's daughter and Power of Attorney (POA) she stated that the facility called her on Monday 04/03/23 and told her about the incident between her mother R #1 and R #2. She stated that she was aware that her mother R #1 and R #2 would hold hands and had seen this while she was at the facility visiting her mother. She stated that when she had become aware of the care plan stating it was ok for them to be in an intimate relationship she stated that she never said that or would have ever allowed that. O. On 04/05/23 at 4:15 pm, during an interview with R #2's brother (not the power the attorney), he stated that to his awareness no one consented to an intimate relationship. It was only ok for them to hold hands. P. On 04/05/23 at 4:31 pm, during an interview with Center Executive Director (CED), he stated that when he first got here R #1 and R #2 would hold hands with each other but nothing more. He stated once the incident happened on 04/03/23, he contacted everyone, the police, SANE, he reported it to the state and contacted the families. The CED stated that R #2 has had a few incidents, one was last Friday (03/31/23) when he pushed a resident and the other on the 03/28/23, he left through the back door and exited the building kicking the outside wooden gate open. Staff followed him out the door and never lost sight of him. He had a meeting with R #1's family members and they were upset about what was noted in the care plan indicating that she had given consent for her mother to have an intimate relationship R #2. He stated that he had the assistant director of nursing remove the parts of the care plan that the family was unhappy with. The son of R #1 filed a restraining order on R #2. Q. On 04/05/23 at 4:51 pm, during an interview with the Social Services Director (SSD), he stated that he met with R #1's family after the incident on 04/03/23, and he stated that during the meeting the daughter of R #1 stated that she never gave permission for a relationship to occur and was upset that her mother was assaulted. He stated that when R #2 tried to elope recently and got out the back door and kicked open the gate, this was the red flag. He stated that something could have been done at that time and maybe this incident wouldn't have occurred. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	R. On 04/06/23 at 8:17 am, during an interview with Certified Nursing Assistant (CNA) #3, she stated that on Monday 04/03/23 she was passing refreshments in the dining room. She heard R #1 state Stop you are hurting me. She said that when she turned around she didn't see anything so she went back to passing snacks. Then she heard R #1 say again I told you stop you're hurting me. She said that the nurse came in and saw right away what was going on. She stated that her and the nurse both tried to get him to stop and he wouldn't. She stated that R #2 got really mad and then finally stopped and then started calling them names. She stated that there has been a lot of issues of concern with what is acceptable and what isn't acceptable for R #1 and R #2. She stated that to her understanding Dementia residents aren't able to consent to having a relationship with each other. She stated that she had been told that they are allowed to have a relationship and to not discipline him. She stated that she hadn't been made aware of this information and wouldn't have understood what that meant anyway (referring to the care plans that stated that both residents were allowed to have a relationship with each other). CNA #3 stated that she was educated and trained that if a resident is in their right mind then they can make those decisions. She said that she would point out that R #2 would inappropriately touch R #1 but was told that they are allowed to be in a relationship. CNA #3 stated that she would stop it (inappropriately touch) every time she saw it. S. On 04/06/23 at 10:10 am, during an interview with Social Services Assistant (SSA), she stated that to her awareness R #1 and R #2 were in a relationship with each other. They would hold hands and wanted to be by each other. She stated that it was care planned that they could be girlfriend and boyfriend. She stated that staff were always trying to keep them separated and she told them to stop, that it was care planned for them to be boyfriend and girlfriend and said that to her that included holding hands, and not going into each others rooms. The SSA stated that R #2 could be vulgar and he was escalating the past two weeks. She stated that with the elopement that happened for R #2 and he was exit seeking and cussing at the nurses this should have been taken more seriously then she thinks it was.

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F 0740 Level of Harm - Actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41738 Based on record review, observation, and interview, the facility failed to provide the necessary behavioral health services for 1 (R #3) of 1 (R #3) resident reviewed. This deficient practice likely resulted in worsening anxiety and depression for R #3. The findings are: A. Record review of R #3's face sheet revealed that she was admitted to the facility on [DATE] with the following diagnoses: recurrent major depressive disorder with severe psychotic symptoms (a medical condition that causes you to experience psychotic symptoms plus the sadness and hopelessness associated with depression such as seeing, hearing, smelling, or believing things that aren't real), unspecified psychosis (a condition that affects the way your brain processes information; it causes you to lose touch with reality) and anxiety disorder (a medical condition that affects the mind and body's reaction to stressful, dangerous, or unfamiliar situations; it is a sense of uneasiness, distress, or dread you feel before a significant event). B. On 04/05/23 at 11:35 am, during an interview and observation, R #3 reported a man named [first and last name of R #4] has been making passes at me (to flirt or make advances to someone, especially of a sexual nature). First in January (2023) and then in February (2023), he would look at me and try to touch me and kiss me and he would follow me around (the facility) and would go down my hall and look in my room too. I told him (R #4) stop, don't touch me and leave me alone, but he does not listen to me. The police come over here (to the facility) when [First name of R #4] does that (stalking, touching and attempted kissing) to me. I was raped a few years ago, so I think about that time (getting raped) every time [first name of R #4] comes near me. I hate talking about it (the rape) and him (R #4), it just makes me so upset. I don't want to talk about it anymore. I have let all of the nurses and [first name of the Social Services Director (SSD)] know about it so a pretty pink whistle was given to me by the tall guy (the facility Administrator) that works here and he told me, 'if he (R #4) goes near you or tries to touch you, just blow the whistle and we (staff) all know about your whistle and we will all come to help you.' Having my whistle makes me feel safe. R #3 was observed crying throughout the interview and appeared visibility shaken when describing her past rape experience and the incidents (of January & February 2023) involving R #4. C. Record review of R #3's care plan revealed: 1. Initiated on 01/19/23 [first name of R #3] to get a whistle and will educate to use it when resident feels unsafe, insecure, or feels sexual advances are occurring. 2. Revised on 03/15/23 [First name of R #3] has a history of sexual abuse. D. On 04/05/23 at 12:14 pm, during an observation and interview, R #3 was crying and stated I wish I could see a counselor to talk to, like I used to do before I came here (to the facility), it helped me a lot and I've asked them (staff), but nobody here gets me one (a counselor). (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	E. On 04/05/23 at 12:16 pm, during an observation, as soon as R #3 was able to see Licensed Practical Nurse (LPN) #2 down the hall, she started to cry harder. LPN #2 asked R #3 what's wrong are you ok? R #3 reported no, I'm upset about what happened to me in February (2023-when R #4 touched R #3's back, grabbed her right forearm and tried to kiss her) and I can't stop worrying about it. LPN #2 said lets help calm you down. R #3 reported I don't know why I have to be worrying about him (R #4), this is my home, I should feel comfortable here. F. On 04/05/23 at 12:19 pm, during an interview, LPN #2 reported that R #3 has had 2 or 3 episodes a week of heightened anxiety since January (2023) due to the unwanted advances of [first name of R #4]. She reported we (staff) just try to calm her (R #3) down as soon as we can and give her anxiety meds as directed by the orders. G. Record review of R #3's order summary dated 12/14/22 Buspirone HCl (hydrochloride-medication used to treat anxiety) tablet 5 mg (milligrams) Give 1 tablet by mouth two times per day for anxiety. H. On 04/05/23 at 1:10 pm, during an observation and interview, R #3 was observed crying outside of the Social Services Directors' (SSD) office. R #3 reported I am still worried about R #4 doing something bad to me so I need my phone so I can call for help, in case I need to. I. On 04/05/23 at 1:35 pm, during an interview, the SSD reported [First name of R #3] is upset, because we have ordered her a cell phone, but it has not come in yet; she has been anxious about this for that last week or so and has spent a lot of time in my office crying; I always let the nurses know (when R #3 is having behaviors) and there is often times a nurse in here (in office) with me trying to calm her down. J. On 04/06/23 at 11:09 am, during an interview, the SSD reported Back in January (2023) [first name of R #3] reported that R #4 was following her, stalking her and looking in her room and had told me and other staff that she was not feeling safe. [First name of R #3] has had a lot of trauma (a deeply disturbing experience) in her past and is hypervigilant (an increased alertness where the individual is constantly assessing potential threats around) in her space. [First name of R #3] got (provided by the Administrator) a whistle to protect her, if in danger at any time. I worked with her (R #3) when she got the whistle to help her understand what it should used for. She (R #3) has meltdowns (outburst of severe emotional distress also known as a nervous breakdown) sometimes several times a week, it just depends and it (having meltdowns) is typical (having distinctive qualities). No one else (other residents) has a whistle, just [First name of R #3]. She (R #3) has never blown it (the whistle), but she has threatened to blow it. R #4 was placed on a behavioral contract (a contract between two or more parties that sets boundaries and is designed to hold the person it is issued to accountable for their actions/behavior) due to this issue (stalking, making physical contact and unwanted advances towards R #3). I discussed the behavioral contract with R #4 and laid out the expectations and he (R #4) is very aware that he needs to stay off of unit 300 (where R #3 resides) and he (R #4) cannot have any interaction with [First name of R #3]. [First name of R #3] is pretty aware of what is going on around her and makes us (staff) aware when she is not comfortable or is upset about anything. SSD confirmed that there have been no recent incidents/contact between R #4 and R #3. K. On 04/12/23 at 1:55 pm, during an interview, the SSD reported that R #3 was in his office upset and crying again this morning when she learned that they still have not received her cell phone. The SSD reported I think she (R #3) would benefit from seeing a therapist on a weekly basis and I have suggested that to the nurses, but that is not happening. (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	L. On 04/12/23 at 2:29 pm, during an interview, the Activities Director (AD) reported [First name of R #3] has psychological (behavioral health related such as those listed in Finding A) issues and the whistle makes her feel safe. She does have episodes of outbursts (anxiety attacks) and the last one I saw her have was on Sunday (04/02/23) when we were playing BINGO. [First name of R #4] said something, I can't remember what, to [First name of R #3] and she stood up and yelled at him, the words they said to each other went over me, but all we can do is keep them separated and calm her down. M. Record review of R #3's order summary dated 10/20/21 revealed Was resident free from behaviors? If no, document behavior, intervention and outcome in PN (progress notes) every day shift and every night shift. N. Record review of R #3's progress notes date range 12/01/22 thru 04/06/23 revealed no documented behaviors and no outreach to Behavioral Health Providers/Specialists. O. Record review of R #3's care plan revised on 03/15/23 revealed Monitor for changes in mental status and functional level and report to MD (Medical Director) as indicated. P. Record review of R #3's care plan revised 03/15/23 revealed [First name of R #3] exhibits distressed/fluctuating mood symptoms R/T (related to) sadness/depression anxieties/fears caused by past trauma & loss of her husband. Observe for signs/symptoms of worsening sadness/depression/anxiety/fear/anger/agitation. Refer to Behavioral Health Specialist as needed. Q. Record review of R #3's progress notes date range 12/01/22 thru 04/06/23 revealed no documented behaviors and no outreach to the Medical Director or any of the Behavioral Health Specialists. R. On 04/25/23 at 1:22 pm, during an interview, Behavioral Health Physician Assistant (BHPA) reported Prior to 04/13/23, we would only see patients (residents) at this facility when we would get a referral for an evaluation, we would then put them (residents) on our caseload and anyone (residents) on psychiatric meds stays on our caseload. R #3 has been on our caseload since she was admitted to the facility. She (R #3) has reported complaints in January and February 2023 of a male touching her, but we don't document names of alleged perpetrators in our notes. She has chronic PTSD (Post Traumatic Stress Disorder) [The First and last name of the Psychiatrist] last saw her (R #3) on 04/02/23, no one saw her from 04/05/23 - 04/12/23 as no one notified us from the facility that she (R #3) was having behaviors. We have a hot list, the facility calls our office and leaves us a message that a resident is in need of BH (Behavioral Health) support and they get added to the hot list and when a patient (resident) gets added to the hot list we go in (to the facility) to see them (residents) right away. I do not remember [First name of R #3] being on the hot list for the month of April (2023). The BHPA confirmed that since R #3 is on psych meds they should have been seeing her at least monthly prior to 04/13/23 and weekly after 04/13/23 and there were no BH visits conducted for R #3 between 02/14/23 and 04/02/23 and does not know the reason for that. S. Record review of R #3's Electronic Medical Record (EMR) revealed no Behavioral Health Progress Notes (also known as SOAP notes-subjective, objective, assessment plan) on file between 02/14/23 and 04/02/23. T. On 04/12/23 at 4:28 pm, during an interview, the Regional Nurse Manager confirmed no Behavioral Health Visits were conducted for R #3 between 02/14/23 and 04/02/23. (continued on next page)

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop, implement, and/or maintain an effective training program for all new and existing staff members. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41738 Based on observation, interview, and record review the facility failed to ensure that staff were properly trained on the implementation of a safety whistle for 1 (R #3) of 1 (R #3) resident reviewed for safety. This deficient practice could likely create confusion amongst staff and residents when the whistle is blown and could also prevent the resident from receiving the assistance needed in an urgent situation, if staff are not properly trained. A. Record review of R #3's face sheet revealed that she was admitted to the facility on [DATE] with the following diagnoses: recurrent major depressive disorder with severe psychotic symptoms (a medical condition that causes you to experience psychotic symptoms plus the sadness and hopelessness associated with depression such as seeing, hearing, smelling, or believing things that aren't real), unspecified psychosis (a condition that affects the way your brain processes information; it causes you to lose touch with reality) and anxiety disorder (a medical condition that affects the mind and body's reaction to stressful, dangerous, or unfamiliar situations; it is a sense of uneasiness, distress, or dread you feel before a significant event). B. On 04/05/23 at 11:35 am, during an interview and observation, R #3 reported a man named [first and last name of R #4] has been making passes at me (to flirt or make advances at someone, especially of a sexual nature). First in January (2023) and then in February (2023), he would look at me and try to touch me and kiss me and he would follow me around (the facility) and would go down my hall and look in my room too. I told him (R #4) to stop, don't touch me and to leave me alone, but he does not listen to me. The police came over here (to the facility) when he tried to kiss me in February (2023). I was raped a few years ago, so I think about that time (getting raped) every time [first name of R #4] comes near me. I hate talking about it (the rape) and him (R #4), it just makes me so upset. I don't want to talk about it anymore. I let all of the nurses and [first name of the Social Services Director (SSD)] know about it, so a pretty pink whistle was given to me by the tall guy (the facility Administrator) that works here and he told me, 'if he (R #4) goes near you or tries to touch you, just blow the whistle and we (staff) all know about your whistle and we will all come to help you. ' Having my whistle makes me feel safe. R #3 was observed crying throughout the interview and appeared visibility shaken when describing her past rape experience and the recent incidents (of January & February 2023) involving R #4. C. Record review of R #3's care plan initiated on 01/19/23 revealed [first name of R #3] to get a whistle and will educate to use it when resident feels unsafe, insecure, or feels sexual advances are occurring. D. Record review of R #3's care plan revised on 03/15/23 revealed [First name of R #3] has a history of sexual abuse. E. On 04/06/23 at 7:03 am, during an interview, Registered Nurse (RN) #1 reported that she works on unit 300 where R #3 resides. RN #1 reported no one told me about a pink whistle that [first name of R #3] wears. I'm just here (at facility on this unit) to pass meds (administer medication to residents). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325032	A. Building B. Wing	04/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sandia Ridge Center	2216 Lester Drive NE Albuquerque, NM 87112

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	F. On 04/06/23 at 7:10 am, during an interview, RN #2 reported that she knows who R #3 is, but was unaware that she wears a pink whistle around her neck for safety reasons. G. On 04/06/23 at 7:18 am, during an interview, Unit Manager/Licensed Practical Nurse (UM/LPN) #1 reported that she oversees unit 200 and R #4 resides on this unit. She reported that she is aware that R #3 wears a safety whistle and that R #3 is to use the whistle anytime she feels unsafe especially with R #4. The UM/LPN #1 reported that the safety whistle was implemented before she started working at the facility and that she was informed about it during a stand up (morning) meeting. She reported that she is unsure how the nursing staff was trained when the safety whistle was first implemented and she is unsure how new staff are trained on the safety whistle when they start working at the facility. H. On 04/06/23 at 7:21 am, during an interview, the Minimum Data Set Coordinator (MDSC) reported that she has not seen the pink whistle that R #3 wears nor has she been trained on what the purpose of the pink whistle is. I. On 04/06/23 at 7:34 am, during an interview, the Assistant Director of Nursing/Unit Manager (ADON/UM) reported that she is aware that R #3 wears a safety whistle and she learned about it during a stand down (morning) meeting. She reported that she did not know how many staff were trained on the safety whistle. The ADON/UM reported I am not even sure if staff were made aware of the safety whistle implementation for [first name of R #3] by being in-serviced (trained in a classroom setting) or if it was done during rounds (trained while on the floor). J. On 04/12/23 at 4:28 pm, during an interview, the Director of Nursing (DON) confirmed that not all staff at the facility were listed on the three sign-in sheets dated 01/23/23 titled Nursing Department Huddle, which included item #8 Safety Whistle for resident and therefore not all staff at the facility had been trained on the implementation of the safety whistle for R #3 or advised of the purpose of the safety whistle when the safety whistle was provided to R #3 on 01/19/23.